General

Guideline Title

The initial management of chronic pelvic pain.

Bibliographic Source(s)

Royal College of Obstetricians and Gynaecologists (RCOG). The initial management of chronic pelvic pain. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2012 May. 16 p. (Green-top Guideline; no. 41). [96 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Royal College of Obstetricians and Gynaecologists (RCOG). The initial management of chronic pelvic pain. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2005 Apr. 12 p. (Guideline; no. 41). [60 references]

Recommendations

Major Recommendations

In addition to these evidence-based recommendations, the guideline development group also identifies points of best clinical practice in the original guideline document.

Classification of evidence levels (1++ to 4) and grades of recommendations (A-D) are defined at the end of the "Major Recommendations" field.

What Are the Possible Aetiological Factors in the Genesis of Chronic Pelvic Pain?

Endometriosis and Adenomyosis

D - Pelvic pain which varies markedly over the menstrual cycle is likely to be attributable to a hormonally driven condition such as endometriosis.

Irritable Bowel Syndrome (IBS) and Interstitial Cystitis

C - Symptoms suggestive of IBS or interstitial cystitis are often present in women with chronic pelvic pain. These conditions may be a primary cause of chronic pelvic pain, a component of chronic pelvic pain or a secondary effect caused by efferent neurological dysfunction in the presence of chronic pain (see section 3.4 in the original guideline document).

Musculoskeletal

C - Musculoskeletal pain may be a primary source of pelvic pain or an additional component resulting from postural changes.

Nerve Entrapment

D - Nerve entrapment in scar tissue, fascia or a narrow foramen may result in pain and dysfunction in the distribution of that nerve.

Psychological and Social Issues

B - Enquiry should be made regarding psychological and social issues which commonly occur in association with chronic pelvic pain; addressing these issues may be important in resolving symptoms.

What Should Underline the Initial Assessment of Chronic Pelvic Pain?

B - The multifactorial nature of chronic pelvic pain should be discussed and explored from the start. The aim should be to develop a partnership between the clinician and the woman to plan a management programme.

History

B - Symptoms alone may be used to diagnose IBS positively in this group (see Appendix 1 in the original guideline document).

On taking the woman's history, special note should be taken of any "red flag" symptoms (see Appendix 2 in the original guideline document) which may need further investigation and referral to a specialist. If the situation allows, it may be helpful to ask directly about past or present sexual assault, particularly intimate partner violence. The doctor must be prepared to listen and accept these experiences as stated and know where to access specialist support.

Completing a daily pain diary for two to three menstrual cycles may help the woman and the doctor identify provoking factors or temporal associations. The information may be useful in understanding the cause of the pain.

It may be helpful to establish the woman’s level of function at the start of treatment (e.g., time off work, avoiding activities), both to monitor progress and to emphasise the value of functional goals. Asking which drugs have been used previously, and whether or not they helped, may be helpful both to aid diagnosis and to plan effective management.

What Investigations Should Be Undertaken?

Screening for Infection

D - All sexually active women with chronic pelvic pain should be offered screening for sexually transmitted infections (STIs).

A positive endocervical sample supports but does not prove the diagnosis of pelvic inflammatory disease (PID). The absence of a result positive for *Chlamydia trachomatis* or gonococcus does not rule out the diagnosis of PID. [Evidence level 4]

If PID is suspected clinically, this condition is best managed in conjunction with a genitourinary medicine physician in order that up-to-date microbiological advice and contact tracing can be arranged. Sexually active women with chronic pelvic pain should be offered screening for STIs. [Evidence level 4]

Transvaginal Scanning (TVS) and Magnetic Resonance Imaging (MRI)

B - Transvaginal scanning is an appropriate investigation to identify and assess adnexal masses.

B - Transvaginal scanning and magnetic resonance imaging are useful tests to diagnose adenomyosis.

Diagnostic Laparoscopy

D - Diagnostic laparoscopy has been regarded in the past as the 'gold standard' in the diagnosis of chronic pelvic pain. It may be better seen as a second-line investigation if other therapeutic interventions fail.

The risks and benefits of diagnostic laparoscopy and the possibility of negative findings should be discussed before the decision is made to perform a laparoscopy. Perhaps it should be performed only when the index of suspicion of adhesive disease or endometriosis requiring surgical intervention is high, or when the patient has specific concerns which could be addressed by diagnostic laparoscopy such as the existence of endometriosis or adhesions potentially affecting her fertility.

What Therapeutic Options Are Available?

B - Women with cyclical pain should be offered a therapeutic trial using hormonal treatment for a period of 3–6 months before having a diagnostic laparoscopy.

A - Women with IBS should be offered a trial with antispasmodics.

C - Women with IBS should be encouraged to amend their diet to attempt to control symptoms.

Definitions:

Grades of Recommendations

A - At least one meta-analysis, systematic review or randomised controlled trial rated as 1++, and directly applicable to the target population; *or*

A systematic review of randomised controlled trials or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results

B - A body of evidence including studies rated as 2++ directly applicable to the target population, and demonstrating overall consistency of results; *or*

Extrapolated evidence from studies rated as 1++ or 1+

C - A body of evidence including studies rated as 2+ directly applicable to the target population and demonstrating overall consistency of results; *or*

Extrapolated evidence from studies rated as 2++

D - Evidence level 3 or 4; *or*

Extrapolated evidence from studies rated as 2+

Good Practice Point - Recommended best practice based on the clinical experience of the guideline development group

Classification of Evidence Levels

1++ High-quality meta-analyses, systematic reviews of randomised controlled trials or randomised controlled trials with a very low risk of bias

1+ Well-conducted meta-analyses, systematic reviews of randomised controlled trials or randomised controlled trials with a low risk of bias

1– Meta-analyses, systematic reviews of randomised controlled trials or randomised controlled trials with a high risk of bias

2++ High-quality systematic reviews of case–control or cohort studies or high-quality case–control or cohort studies with a very low risk of confounding, bias, or chance and a high probability that the relationship is causal

2+ Well-conducted case–control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal

2– Case–control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal

3 Non-analytical studies, e.g., case reports, case series

4 Expert opinion

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Chronic pelvic pain

Guideline Category

Diagnosis

Evaluation

Management

Treatment

Clinical Specialty

Family Practice

Internal Medicine

Obstetrics and Gynecology

Intended Users

Advanced Practice Nurses

Nurses

Physician Assistants

Physicians

Guideline Objective(s)

To provide an evidence-based summary for the generalist to facilitate appropriate investigation and management of women presenting for the first time with chronic pelvic pain

Target Population

Women with chronic pelvic pain

Interventions and Practices Considered

Diagnostic Assessment

1. Patient history and symptom assessment, including psychological, bladder and bowel symptoms
2. Physical examination
3. Establish the woman's level of function at the start of treatment (e.g., time off work, avoiding activities
4. Screening for chlamydia, gonorrhoea, and other sexually transmitted diseases
5. Completion of pain diary
6. Diagnostic laparoscopy a second-line investigation if other therapeutic interventions fail
7. Imaging to diagnose adenomyosis
    - Transvaginal scanning (TVS)
    - Magnetic resonance imaging
8. Addressing psychological and psychosocial issues

Treatment

1. Hormonal treatment for a period of 3–6 months
    - Oral contraceptive pill, progestogens, danazol or Gonadotropin-releasing hormone (GnRH) analogues
    - Levonorgestrel-releasing intrauterine system

2. Antispasmodics for irritable bowel syndrome (IBS)
3. Referral to a pain management team or a specialist pelvic pain clinic if necessary
4. Dietary modification for IBS
5. Analgesics for pain

Major Outcomes Considered

- Risk for chronic pelvic pain
- Pain control
- Adverse effects of treatment
- Accuracy of diagnostic tests

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

The Cochrane Library and the Cochrane Register of Controlled Trials were searched for relevant randomised controlled trials, systematic reviews, and meta-analyses. A search of Medline from 1966 to July 2011 was also carried out. The database was searched using the Medical Subject Heading (MeSH) terms "pelvic pain," "dysmenorrhoea," and "chronic disease," including all subheadings. This was combined with a keywords search using the terms "chronic pelvic pain" and "dysmenorrhoea."

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Classification of Evidence Levels

1++ High-quality meta-analyses, systematic reviews of randomised controlled trials or randomised controlled trials with a very low risk of bias

1+ Well-conducted meta-analyses, systematic reviews of randomised controlled trials or randomised controlled trials with a low risk of bias

1– Meta-analyses, systematic reviews of randomised controlled trials or randomised controlled trials with a high risk of bias

2++ High-quality systematic reviews of case–control or cohort studies or high-quality case–control or cohort studies with a very low risk of confounding, bias, or chance and a high probability that the relationship is causal

2+ Well-conducted case–control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal

2– Case–control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal

3 Non-analytical studies, e.g., case reports, case series

4 Expert opinion

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

Reviewing and Grading of Evidence

Once the evidence has been collated for each clinical question it needs to be appraised and reviewed (refer to section 3 in "Development of RCOG Green-top guidelines: producing a clinical practice guideline" for information on the formulation of the clinical questions; see the "Availability of Companion Documents" field). For each question, the study type with least chance of bias should be used. If available, randomised controlled trials (RCTs) of suitable size and quality should be used in preference to observational data. This may vary depending on the outcome being examined.

The level of evidence and the grade of the recommendations used in this guideline originate from the guidance by the Scottish Intercollegiate Guidelines Network (SIGN) Grading Review Group, which incorporates formal assessment of the methodological quality, quantity, consistency, and applicability of the evidence base. The methods used to appraise individual study types are available from the SIGN Web site (www.sign.ac.uk/methodology/checklists.html). An objective appraisal of study quality is essential, but paired reviewing by guideline leads may be impractical because of resource constraints.

Once evidence has been collated and appraised, it can be graded. A judgement on the quality of the evidence will be necessary using the grading system (see the "Rating Scheme for the Strength of the Evidence" field). Where evidence is felt to warrant 'down-grading', for whatever reason, the rationale must be stated. Evidence judged to be of poor quality can be excluded. Any study with a high chance of bias (either 1– or 2–) will be excluded from the guideline and recommendations will not be based on this evidence. This prevents recommendations being based on poor-quality RCTs when higher-quality observational evidence is available.

Methods Used to Formulate the Recommendations

Expert Consensus

Informal Consensus

Description of Methods Used to Formulate the Recommendations

Guideline Development

The development of guidelines involves more than the collation and reviewing of evidence. Even with high-quality data from systematic reviews of randomised controlled trials, a value judgement is needed when comparing one therapy with another. This will therefore introduce the need for consensus.

Royal College of Obstetricians and Gynaecologists (RCOG) Green-top guidelines are drafted by nominated developers, in contrast to other guideline groups such as the National Institute for Health and Clinical Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN), who use larger guideline development groups. Equally, in contrast to other guideline groups, the topics chosen for development as Green-top guidelines are concise enough to allow development by a smaller group of individuals.

In agreeing the precise wording of evidence-based guideline recommendations and in developing consensus-based 'good practice points', the Guidelines Committee (GC) will employ an informal consensus approach through group discussion. In line with current methodologies, the entire development process will follow strict guidance and be both transparent and robust. The RCOG acknowledges that formal consensus methods have been described, but these require further evaluation in the context of clinical guideline development. It is envisaged that this will not detract from the rigor of the process but prevent undue delays in development.

Rating Scheme for the Strength of the Recommendations

Grades of Recommendations

A - At least one meta-analysis, systematic review or randomised controlled trial rated as 1++, and directly applicable to the target population; *or*

A systematic review of randomised controlled trials or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results

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Extrapolated evidence from studies rated as 1++ or 1+

C - A body of evidence including studies rated as 2+ directly applicable to the target population and demonstrating overall consistency of results; *or*

Extrapolated evidence from studies rated as 2++

D - Evidence level 3 or 4; *or*

Extrapolated evidence from studies rated as 2+

Good Practice Point - Recommended best practice based on the clinical experience of the guideline development group

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Following discussion in the Guidelines Committee (GC), each Green-top guideline is formally peer reviewed. At the same time, the draft guideline is published on the Royal College of Obstetricians and Gynaecologists (RCOG) Web site for further peer discussion before final publication.

All comments will be collated by the RCOG and tabulated for consideration by the guideline leads. Each comment will require discussion. Where comments are rejected then justification will need to be made. Following this review, the document will be updated and the GC will then review the revised draft and the table of comments.

Once the GC signs-off on the guideline, it is submitted to the Standards Board for approval before final publication.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Living with any chronic pain carries a heavy economic and social burden. Aiming for accurate diagnosis and effective management from the first presentation may help to reduce the disruption of the woman's life and may avoid an endless succession of referrals, investigations and operations.

Potential Harms

- Diagnostic laparoscopy carries significant risks: an estimated risk of death of approximately 1.0/10,000 and a risk of injury to bowel, bladder, or blood vessel of approximately 2.4/1,000, of whom two-thirds will require laparotomy.
- There may be adverse consequences of a negative laparoscopy. Many women may feel disappointed that no diagnosis has been made. This set of events may lead to disengagement with the medical process.
- Adverse effects of ovarian suppression and other pharmacological therapy

Qualifying Statements

Qualifying Statements

- These recommendations are not intended to dictate an exclusive course of management or treatment. They must be evaluated with reference to individual patient needs, resources and limitations unique to the institution and variations in local populations. It is hoped that this process of local ownership will help to incorporate these guidelines into routine practice. Attention is drawn to areas of clinical uncertainty where further research might be indicated.
- The Royal College of Obstetricians and Gynaecologists (RCOG) produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of clinical data presented by the patient and the diagnostic and treatment options available. This means that RCOG Guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Audit Criteria/Indicators

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Royal College of Obstetricians and Gynaecologists (RCOG). The initial management of chronic pelvic pain. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2012 May. 16 p. (Green-top Guideline; no. 41). [96 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2005 Apr (revised 2012 May)

Guideline Developer(s)

Royal College of Obstetricians and Gynaecologists - Medical Specialty Society

Source(s) of Funding

Royal College of Obstetricians and Gynaecologists

Guideline Committee

Guidelines Committee

Composition of Group That Authored the Guideline

Authors: Ms SJ Moore MRCOG, Oxford; Mr SH Kennedy MRCOG, Oxford

Peer Reviewers: Dr U Krishnamoorthy, East Lancashire; College of Emergency Medicine; Consumers' Forum; Obstetric Anaesthetists' Association (OAA); Royal College of Midwives (RCM); Women's Health Pharmacist Group

Guidelines Committee Lead Reviewers: Dr AJ Thomson MRCOG Paisley, Scotland; Dr KR Harding FRCOG, London

Financial Disclosures/Conflicts of Interest

None declared

Guideline Status

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This guideline updates a previous version: Royal College of Obstetricians and Gynaecologists (RCOG). The initial management of chronic pelvic pain. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2005 Apr. 12 p. (Guideline; no. 41). [60 references]

Guideline Availability

Electronic copies: Available from the Royal College of Obstetricians and Gynaecologists (RCOG) Web site .

Availability of Companion Documents

The following are available:

- Development of RCOG Green-top guidelines: policies and processes. Clinical Governance Advice No 1a. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2006 Nov. 6 p. Electronic copies: Available from the Royal College of Obstetricians and Gynaecologists (RCOG) Web site .
- Development of RCOG Green-top guidelines: producing a scope. Clinical Governance Advice No 1b. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2006 Nov. 4 p. Electronic copies: Available from the RCOG Web site .
- Development of RCOG Green-top guidelines: producing a clinical practice guideline. Clinical Governance Advice No 1c. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2006 Nov. 13 p. Electronic copies: Available from the RCOG Web site .
- Development of RCOG Green-top guidelines: consensus methods for adaptation of Green-top guidelines. Clinical Governance Advice No 1d. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2010 Feb. 9 p. Electronic copies: Available from the RCOG Web site .

In addition, suggested audit topics are available in section 9 of the original guideline document .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI on October 14, 2005. This NGC summary was updated by ECRI Institute on July 17, 2012. The updated information was verified by the guideline developer on September 25, 2012.

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